Commentary

Academe and Government
Firm Link or Broken Reed?

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The federal government has been such an important partner in many academic medical center activities that we take both its presence and the support it provides to our institutions for granted.* We tend to comment on the relationship only when we think it is going awry because of changes in federal policy or funding. We seldom question whether those in the federal government think the relationship has faltered through some action or inaction of our own. The link between the federal government and academic medical centers is unique and pervasive. That involvement relates to the following activities of the academic medical center:

- The research activities of medical faculty have been primarily supported by the National Institutes of Health (NIH), based on a policy decision that it would be in the government's best interest to support a broad array of research projects primarily through universities rather than through independent research institutes or intramural laboratories.
- The teaching activities of the academic medical center have been supported less directly, but supported nonetheless, through programs such as the now defunct capitation initiative, through project grants for special curricular innovations, and through the student assistance programs that finance medical student education.
- Federal involvement in patient care activities evolved through the passage of Medicaid and Medicare legislation in the mid-1960s, assuring medical centers of a payment source for elderly and indigent patients who are disproportionately treated at academic medical centers and their affiliated hospitals.
- The affiliations that exist between medical schools and the hospitals of the Department of Veterans Affairs crosscut all activities of academic medical centers and contribute to their research, patient care, and teaching missions.

The level of federal support for the activities of academic medical centers during the past three decades has been substantial, although a notable decline has occurred in the proportion of overall support that comes from federal dollars. Nevertheless, the federal contribution to medical school activities in fiscal year 1991 amounted to more than $4.6 billion (Figure 1). During this same 30-year period we also saw an enormous increase in the proportion of medical school revenues from medical service income, which rose from $28 million to $9.4 billion (Figure 2). Of personal health care expenditures, 30% are borne by Medicare and Medicaid, which play a substantial federal role in generating medical school income.

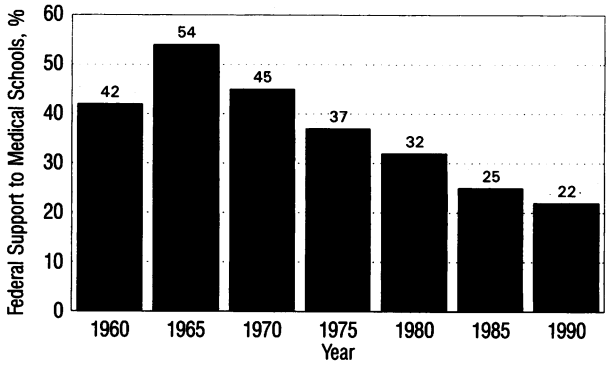

Figure 1.—The proportion of medical school revenues from the federal government, excluding services, has fallen from 54% in 1965 to 22% in 1990.

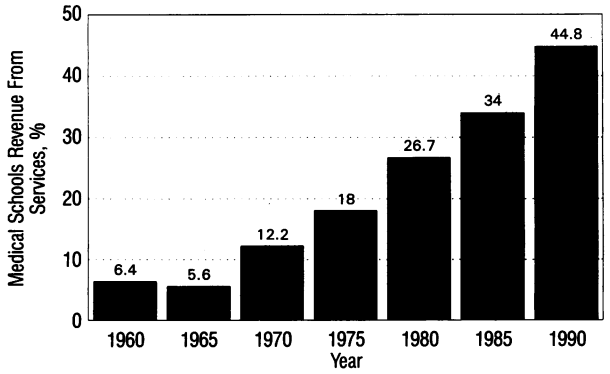

Figure 2.—Medical services as a source of medical school revenues have risen steadily since 1965.

*See also the editorial by Lloyd H. Smith, Jr, MD, "Government and the Academic Health Science Center" on pages 211-212 of this issue.

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ABBREVIATIONS USED IN TEXT

GME = graduate medical education
IME = indirect medical education [adjustment]
NIH = National Institutes of Health
PPS = prospective payment system
VA = Veterans Administration [Department of Veterans Affairs]

It seems especially appropriate in these early months of the Clinton Administration to be discussing the link between the federal government and our academic medical centers. After 12 years of a Republican administration, we can surely expect to see President Clinton proposing changes. The most fundamental change affecting our institutions will likely be in the realm of health care reform and related efforts to control costs.

Research

For most of the 1960s and 1970s the federal government accounted for about 60% of the national annual investment in biomedical research; industry accounted for 25% to 30%. This situation is the consequence of a major federal investment in biomedical research that began with World War II. Contributions by private industry to research funding accelerated in the 1980s, spurred by advances in biotechnology, pharmaceuticals, and medical instrumentation. By 1990, of the $23 billion in total research and development expenditures, about 46% was funded by private industry, 42% by the federal government, and 12% from other sources, including states and private, nonprofit foundations and agencies.

In the medical school setting, however, despite the initiation of academic partnerships with industry, the main sponsors of faculty research have been federal agencies. In 1991, medical schools reported receiving sponsored research funding of $3.4 billion, of which three fourths was provided by the federal government, most of that from the NIH. As a result, the funding patterns, the leadership, and the major policy directions of NIH are a focus of intense interest to the academic community.

In the 1950s and 1960s, annual growth in NIH appropriations was brisk—more than 20% after inflation. In the 1970s, growth in support continued but was more modest—approximately 5% annually. In the 1980s the size of funding increases diminished considerably, giving rise to conflicts within the biomedical community about the appropriate allocation of funds within programmatic divisions and within funding mechanisms (Figure 3).

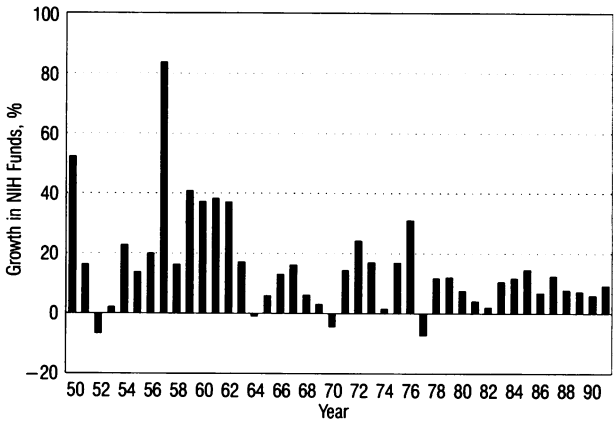

Figure 3.—The yearly growth in total congressional appropriations to the National Institutes of Health (NIH) stabilized in the 1980s (personal communication from the Division of Financial Management, NIH).

National Institutes of Health Strategic Plan

The plateau in funding led to an important unfinished chapter from the last administration, the NIH Strategic Plan.[1] Then-Director Bernadine Healy thought that the plan would be the instrument to revive lagging biomedical research funding.

When last reviewed, the plan was 400 pages long. Despite its length, the plan's design was comparatively simple, consisting of a mission statement, four specific goals, six trans-NIH objectives, and an implementation strategy. The meat of the plan is contained in the six trans-NIH objectives:

- *The advancement of critical science and technology.* Under this rubric are contained molecular medicine, biotechnology, molecular immunology and vaccine development, structural biology, and cellular and integrative biology.
- *Progress on critical health needs.* This objective covers biology and the environment, child health, chronic illness, and the health of minorities and underserved populations.
- *Increased investment in intellectual capital.* The third objective deals with development of the talent base, the importance of public understanding of science, and professional standards for scientific research. The issue here is whether the human and fiscal capital will be available to implement these objectives.
- *Improvement and expansion of research capacity.* This plank deals with research facilities, instrumentation, and computational research and touches on the role of the NIH intramural programs. The bottom line: more money.
- *Improved stewardship of public resources.* Under this objective are lumped the mechanisms of extramural funding, such as R01s (individual investigator-initiated grants to support discrete, circumscribed projects) versus program projects or centers; ways in which priorities are set; and the complex issues of peer review. The peer review process may be due for some overhaul.
- *Solidification of public trust.* This objective deals with improving NIH's public image, an objective with which few could argue.

The reaction of the extramural community to the plan, though initially somewhat rancorous, settled some time ago into a state of cool civility.[2] Despite all the effort to solicit external advice, there seems to be skepticism concerning the planning effort and its effect on extramural research programs. Some question the need for the plan at all, given the existing planning efforts of individual institutes. Some are uncomfortable with the emphasis of the

plan on national economic returns as a justification for research. The concern is that, based on the plan, NIH will derive its priorities with too heavy an emphasis on political and economic considerations and insufficient regard for investigator-initiated ideas and scientific opportunity. Related to this concern is the fear that an investigator whose work does not fall within a "critical technology" will be at a disadvantage.

The plan's future is somewhat uncertain. The final document is in the process of being edited and pared down to about 100 pages. The receptivity of the Clinton Administration to the plan is unknown, but it is hard to imagine, given the substantial resources required to produce it, that the plan could be rejected out of hand.

Justifying Research on Economic and Social Grounds

One topic receiving progressively more attention is the extent to which public support of research should be justified on grounds other than the intrinsically noble pursuit of scientific truth. For many, science for science's sake is no longer sufficient justification. Congress and, presumably, the public are increasingly looking to research for economic returns and direct applications and benefits for public health.

An emphasis on economic and societal returns is cropping up not only in the strategic plan but in other venues. Representative George Brown (Democrat, California), Chair of the House Committee on Science, Space, and Technology, thinks there is a worrisome gap between the knowledge that our scientific enterprise is yielding and the needs of our society. A report to his committee by a specially convened task force called for developing mechanisms to link research to the long-term national goals of "economic competitiveness, human health, and environmental protection."[3] Brown himself emphasized this view when he wrote,

> Society needs to negotiate a new contract with the scientific community. The contract must be rooted in the pursuit of explicit, long-term social goals. . . . A new contract will measure the value of research and innovation not by number of publications or citations or patents, but by progress toward these specific goals ("It's Down to the Last Blank Check," *Los Angeles Times,* September 8, 1992, p 5).

The Carnegie Commission on Science, Technology, and Government recently released a report that identifies "a reliable, sustainable, and competitive economy" as one of four major classes of societal objectives to be met by our scientific endeavors.[4]

The emphasis on social and economic returns from the public investment in research has been beneficial for academic institutions. This emphasis has led to policies that have allowed them to profit financially from innovations derived with federal support. At the same time, the effect of these policies on the academic culture and on the NIH has been called into question. The fear, of course, is that unfettered exploration of new scientific opportunities will become a thing of the past, supplanted by a single-minded drive toward all things profitable; that NIH's tradition of supporting the research ideas that flow freely from the wellspring of our investigators' creative minds will be overtaken by an overly constrained, economically driven research agenda. Economic competitiveness should be a natural derivative of a vigorous national biomedical research enterprise, but not a primary goal. We must recognize the important benefits stemming from the growing collaborations between industry and academia, but underscore NIH's vital role in supporting the academic values of our institutions and in assuring healthy and vigorous national programs in support of fundamental research.

The New Administration

How the transition from a Republican to a Democratic administration will affect biomedical research is not entirely clear, though based on comments Clinton made during his campaign, it is likely that there will be continued emphasis on the link between basic research and economic success. In an interview published in *Science*, Clinton said[5]:

> The linkages between basic research and technology are becoming increasingly prevalent. The absence of a clear technology policy is one of the key reasons why America is trailing some of its major competitors in translating its strength in basic research into *commercial success* [emphasis added].

The persons who Clinton appoints to key positions within the administration will influence many aspects of the research agenda, and it may be some time before we see how that agenda is evolving.

Education

Federal government support for medical education has been confined to specific, targeted initiatives, generally related to workforce policy. The most comprehensive example of these programs occurred 30 years ago when Congress enacted the Health Professions Educational Assistance Act.[6] The major impetus for passage of the act was the public perception that the number of physicians in the United States was inadequate. The legislation sought to alleviate this problem by providing funds for the construction of teaching facilities, for loans, and later, for scholarships for students in the health professions.

Amendments to the legislation expanded the scope of government assistance to medical education by providing funds for educational improvements and other special projects and eventually for capitation grants based on class size. Participation in the program was tied to a commitment by the schools to expand class size to address the perceived physician shortage that was the original impetus for the legislation.

Despite the opposition of organized medicine, academic medicine welcomed this federal largesse and responded enthusiastically, increasing the number of medical schools by 50%—from 83 at the time the legislation was passed to 126 today. The number of medical students doubled in this same period from just over 31,000 to a peak enrollment of more than 67,000 in 1984 (Figure 4).

As early as 1970 Congress considered that it was essential not only to promote the production of physicians

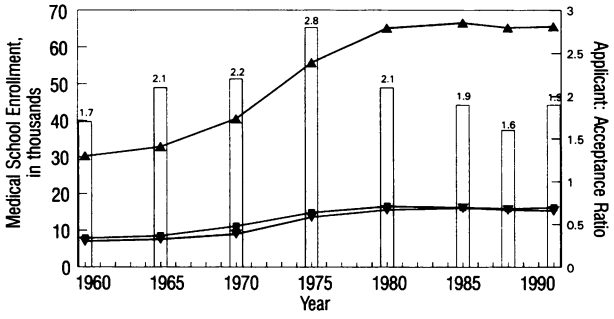

Figure 4.—During the 1980s medical school enrollment stayed steady (▲ = total enrollment, ■ = first-year new entrants, ▼ = graduates) despite a sharp decline in medical school applicants (vertical bars) since a historical high in 1975 (from the AAMC Data Book, Association of American Medical Colleges, Washington, DC, 1992).

generally but particularly to increase the number of primary care physicians. Just a decade after the passage of the original authorizing legislation, public policymakers had discovered a hard truth—that merely increasing the number of physicians apparently was not going to solve the country's health problems and physician distribution inequities. Federal policy shifted, and general assistance to medical education was eliminated in favor of support for more targeted programs. As Senator Richard Schweiker said of this legislative shift[7]:

So long as the medical education system is going to accept and demand 55% federal support, we in the federal government have a right to ask that doctors be in the right place and trained in the right specialty.

This view was echoed two years later when the Secretary of Health, Education and Welfare at the time, Joseph Califano, addressed the 1978 annual meeting of the Association of American Medical Colleges. The gist of his talk included a charge that medical schools were not training a sufficient number of primary care physicians and that the physician community must become more responsive to demographic, social, and economic forces. He called the decline in the proportion of primary care physicians "disturbing" and said,[8]

Already we can see some unhappy results of this sharp decline in primary care physicians. Large numbers of patients are resorting to hospital emergency rooms for care because they do not have access to a family physician. The health care market place is becoming increasingly confused as patients act as their own medical managers, referring themselves to highly sophisticated specialists for relatively routine complaints. This is not only inappropriate but expensive. The entire health care delivery system is unnecessarily skewed toward the most expensive specialty end of the spectrum.

Califano was absolutely on target in this assessment, and his remarks remain as true today as they were 15 years ago. It is noteworthy that as long as 15 years ago important policymakers in both the executive and legislative branches were "fed up" with the inability of the medical education system to respond to a national need for more primary care physicians. The medical profession should consider itself lucky that there has not been a specific legislative initiative that would mandate changes in medical student and resident education to accomplish the goal of more primary care physicians. Perhaps this respite can be credited to the change in the philosophy of what government should do, as opposed to what it can do, that was the hallmark of the "Reagan Revolution," but it is clear that both the philosophy and the policies of that revolution are in the process of being reversed.

Today, there are only a few categorical grant programs that are the legacy of the original federal incursion into medical education (Table 1). In fiscal year 1993 they will provide $90 million to support various primary care efforts, including attempts to promote medical education in rural areas through the area health education centers.

A less direct federal method of supporting medical education has been the student assistance programs (Figure 5). In the academic year 1990-1991, $826.5 million in loans and scholarships was made available to medical students, of which more than three fourths relied on federal support.

TABLE 1.—*Federal Government Support of Medical Education, Fiscal Year 1993*

Federal Program	*Appropriation, in million $*
Area health education centers	19.8
Family medicine departments	5.5
General internal medicine and pediatrics	16.9
Family medicine residencies	32.7
Preventive medicine residencies	1.6
Geriatric training and research	13.6

A disturbing phenomenon occurred in the previous Congress with the reauthorization of some of these programs. The reauthorizing legislation deliberately incorporated primary care requirements into three student financial aid programs that had previously been strictly needs-based. Notice has been served that additional student aid programs facing reauthorization in 1993 may include similar restrictions. Serious questions have been raised about the equity of creating these dual objectives and requirements. These new requirements to render medical service in primary care can be interpreted as im-

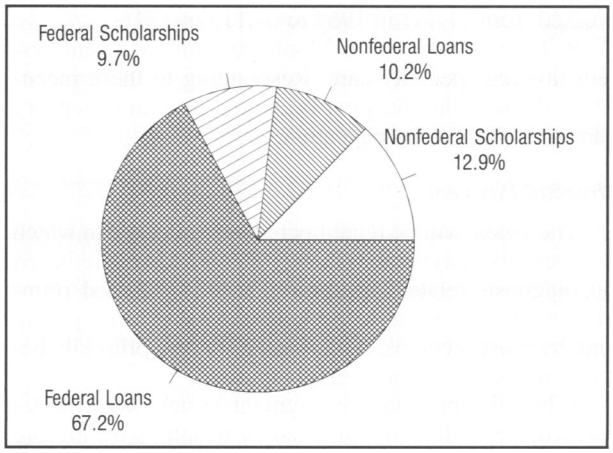

Figure 5.—Federal loan programs are the major source of medical student financial assistance.

posing a disproportionate responsibility for fulfilling community-oriented personnel needs on needy students.

Besides the more restrictive provisions for students seeking such financial assistance, these health professions student loan programs impose stiff penalties on the sponsoring schools that have too few graduates selecting primary care as a career option. These schools will be required to return to the government a portion of the federally contributed capital in the institution's revolving loan fund, decreasing funds available for students in future years.

A message is being sent to our community that we have failed to meet the perceived national need for generalist physicians and that coercive methods will be used if we continue to fail to respond to this need voluntarily.

Patient Care

The institution of Medicare and Medicaid in 1965 had several profound effects on academic medical centers:

- Medicare and, to a lesser extent, Medicaid provided financial stability for academic medical centers by identifying a payment source for patients who had previously been given charity care. This was especially important for medical schools located in inner cities and in other areas with large medically indigent populations.
- From the beginning, the Medicare legislation explicitly included the cost of graduate medical education (GME) as a legitimate component of reimbursement for patient care. This not only stabilized GME programs and their financing, but probably contributed to the growth of residencies and fellowships.
- With faculty members able to secure reimbursement for more of their patient care, the practice plan became a viable source of income to support other medical center activities.
- Clinical work became as central to the academic enterprise as did teaching and research; to respond to the clinical mandate, new systems of faculty appointment, evaluation, and advancement were established. An exponential growth in the number of clinical faculty occurred; the number of full-time faculty in clinical departments increased from 11,447 in 1965 to 64,115 in 1991.
- The structure of the Medicare reimbursement system favored specialty care. Responding to these incentives, the teaching hospital became a bastion of tertiary care and subspecialty education.

Hospital Payment

The 1980s will be remembered as the decade in which a prospective payment system (PPS) for Medicare based on diagnosis-related groups replaced cost-based reimbursement. We are now in the tenth year of this system, and, by most accounts, it has been a success primarily because it has constrained costs (Figure 6).

When the prospective payment system was implemented, it was feared that teaching hospitals would fare the worst. Reality has not borne out these fears (Figure 7). As a group, teaching hospitals continue to have higher

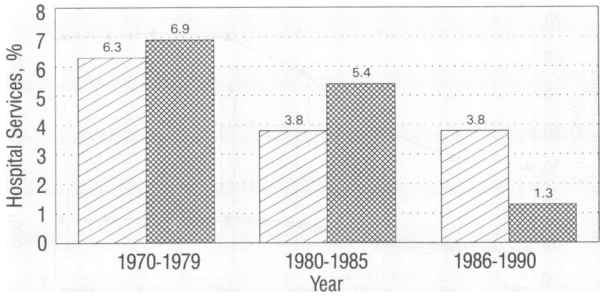

Figure 6.—Changes in real national and Medicare hospital expenditures, per capita and per enrollee, are shown. With the advent of the prospective payment system, Medicare expenditures (▩) for hospitals increased less rapidly than the national average (▨) (from Medicare and the Prospective Payment Assessment Commission).[9(p17)]

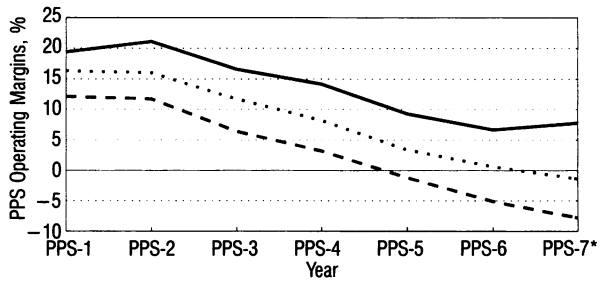

Figure 7.—Operating margins for teaching hospitals in the first 7 years of Medicare's prospective payment system (PPS) are greater for major and other teaching hospitals (solid line, dotted line) than for nonteaching hospitals (dashed line) (from Medicare and the Prospective Payment Assessment Commission).[9(p52)] * = preliminary data

operating margins under the system than do nonteaching hospitals because teaching hospitals receive a special payment adjustment, the indirect medical education adjustment (IME), for their higher costs associated with severity of illness and the presence of graduate physician trainees. Many, but by no means all, teaching hospitals also receive the disproportionate share adjustment, a mechanism for transferring additional federal funds to hospitals that serve a large share of Medicaid and other low-income patients. Hospitals that get both these adjustments in payments have the highest PPS margins of any group at 3.8%. Hospitals that get only IME payments have negative PPS margins (Figure 8).

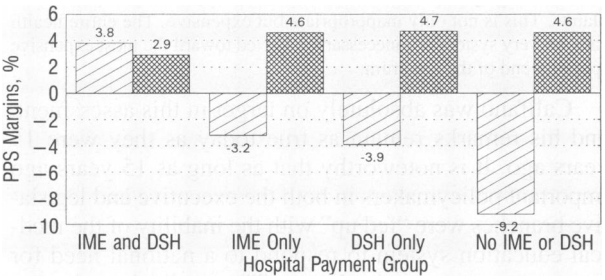

Figure 8.—In the 7th year of the prospective payment system (PPS), hospitals that get both indirect medical education adjustments (IME) and disproportionate share (DSH) payments had the highest PPS (▨) but not total (▩) margins of any hospital group (from ProPAC and the Prospective Payment Assessment Commission).[9(pp52,64)]

Some argue that the IME and other PPS payments can be reduced because average total margins, as opposed to PPS margins, across all types of hospitals are relatively healthy (Figure 8). The average total margin for all hospitals was more than 4% in 1990, but hospitals that receive both IME and disproportionate-share payments continue to have lower total margins (2.9%) than any other group because of their greater number of below-cost and nonpay patients.

Policymakers have argued that once access is expanded through health care reform, IME and PPS adjustments could be reduced or even eliminated without harming teaching hospitals. We disagree with this view and have argued that the purpose of payment for indirect medical education is not to finance uncompensated care, but to recognize factors that legitimately increase costs in teaching hospitals. Even when the health care system is reformed, cost differences between teaching and nonteaching hospitals will continue to exist, and the payment system must recognize this empirical fact through a special adjustment that "levels the playing field" and allows teaching hospitals to compete.

Another unique cost of teaching hospitals that threatens their ability to compete is the direct cost of graduate medical education. These costs include residents' stipends and benefits, salaries and benefits of teaching and supervising faculty, and overhead costs. If the 1980s was the decade of prospective payment systems, the 1990s will be the one of managed care, negotiated rates, and discounted prices. As payers turn toward these new payment mechanisms, some in the academic hospital community have suggested that they could negotiate more effectively if the costs of GME were removed from their operating budgets and were paid separately from a national fund to which all payers would contribute. The question of whether separate streams of revenue will be available to support the many missions of teaching hospitals will continue to be vigorously debated.

At the same time, the federal government is questioning the value it receives for the Medicare dollars it spends —$1.6 billion in 1992—to support its share of the direct costs of graduate medical education. Those who determine Medicare policy have objected to the wide variation in per-resident costs among teaching hospitals. Many fail to understand that at some institutions, faculty in clinical departments depend more on the hospital than on the university for their support. More important, both the Clinton Administration and Congress are frustrated that the medical education community has not met the nation's need for primary care physicians. As their frustration increases, specific suggestions for providing disincentives for nongeneralist training have been proposed. Some would reduce the present support for specialty training by making differential per-resident payments based on specialty. Payments for residents would be weighted more heavily toward trainees in primary care programs such as general internal medicine, pediatrics, and family medicine than for residents in nongeneralist specialties. Some proposals would mandate higher stipends for primary care residents, and others would reduce the variation in direct GME payments. Some proposals recommend channeling GME funds through local consortia that might be more responsive to health professions planning objectives.

We at the Association of American Medical Colleges have opposed proposals to change Medicare direct GME payments, but it is uncertain whether our position will continue to carry the day. The Physician Payment Review Commission and the Prospective Payment Assessment Commission are studying direct GME payments, and both bodies will make recommendations this year that will be taken seriously by the policymakers. We have pointed out that as long as there are unfilled primary care residency positions, proposals to weight hospital payments are unlikely to work. There is also no evidence that medical students' specialty choices are influenced by the level of hospital payments. These proposals have the potential to cause divisiveness within an institution because there will be pressure from disciplines such as emergency medicine, child psychiatry, and physical medicine to be subsumed under the primary care umbrella.

Pressure to reduce the growth in both public and private payers' payments for health care and to redress the physician specialty imbalance will increase in the months and even years ahead. The academic medicine community needs to identify constructive avenues for change.

Physician Payment

In addition to changes proposed for Medicare reimbursement to teaching hospitals, substantial changes have occurred with the introduction of the Medicare fee schedule—the resource-based relative value system. There has been a growing national dependence on practice plan revenues to sustain the basic programs of the medical school. In fiscal year 1990-1991, practice plan income represented an average of 31.4% of medical schools' operating revenue. In some schools, this may be as high as 40% to 50%. Deans across the country are concerned that this fee schedule will result in declining professional fee income that, in turn, will translate into less income for medical schools. This is likely to happen.

By design, the Medicare fee schedule, through the use of a resource-based relative value system, was intended to provide a more equitable way to pay physicians and to eliminate incentives to enter lucrative specialties by paying more for evaluation and management services and less for procedural services. It was also intended to reduce payment to physicians in overpriced urban areas and to reduce the use of technologic procedures, which many think are done to excess. The gains in payment to primary care physicians for historically undervalued evaluation and management services have been disappointing, and one can only conclude that the Medicare fee schedule provides a limited incentive for medical students to select a primary care career.

The effect of the Medicare fee schedule on physician income is highly dependent on the variables of service mix and geographic location. Impact simulations done by

the Physician Payment Review Commission and the Health Care Financing Administration demonstrate that many faculty practice plans will lose substantial revenue under the Medicare fee schedule. Academic physicians, in particular, fit the profile of the "losing" physician. For the most part, they are procedurally oriented and typically are located in an urban area where physician charges have historically been high.

There are also a number of payment policy issues and technical problems with the fee schedule that remain to be resolved. These are arcane, and to discuss them knowledgeably requires a presentation in greater detail than can be covered in this article. Let us merely highlight a few issues of concern.

First, adjustments are needed to account for differences in case complexity and patient severity. Although the Medicare prospective payment system for hospitals adjusts for severity of illness of patients treated in teaching institutions, the Medicare fee schedule does not. Payment to critical care physicians who may spend many hours at the bedside without adequate remuneration is a case in point.

A second major issue is the method for calculating the practice expense component of the fee schedule, using a resource-based approach. Implementing the resource-based method will result in additional cuts in payments for surgical services and may seriously jeopardize the financial stability of many academic practice plans.

A third issue is the Medicare Volume Performance Standard on which the annual update of physician fees is based. The Medicare Volume Performance Standard was intended to provide physicians with a "collective incentive" to keep Medicare expenditures within a targeted national level each year. Should aggregate physician expenditures go above Medicare's standard, fee updates for the subsequent year would be lowered to offset the rise in volume. The major concern with the volume performance standard is that the volume estimates provided Congress by the Physician Payment Review Commission and the Health Care Financing Administration do not accurately reflect the volume and intensity of physicians' practice that is often beyond the control of individual physicians. In addition to the apparent inaccuracy of the volume estimates, the current national scope of the performance standards provides little, if any, incentive to individual physicians or to even large physician groups to modify their behavior if they feel that they have little or no effect on meeting the overall national standard. An alternative approach recommended by the Physician Payment Review Commission is the development of different performance standards for "qualified" groups of physicians. These groups would allow physicians to receive payment updates based on their own performance rather than on the performance of physicians in general. Coupled with the right incentives to practice efficiently, this may be a more worthwhile course than a national performance standard.

There appears to be a fair amount of interest in having third-party payers adopt the Medicare fee schedule. Expanding the fee schedule to private payers would effectively redress the pricing of services and procedures by applying a more rational and scientific approach to the payment of physicians.

Department of Veterans Affairs

In a 1946 Veterans Administration (VA) policy memorandum, the affiliation between VA hospitals (now called medical centers) and medical schools was established.[10] The memorandum lays out the responsibilities of all involved parties, including the Veterans Administration (now Department of Veterans Affairs), schools of medicine, hospital managers, chiefs of service, part-time attending staff, and consultants. This policy memorandum represented an interesting blend of realism, trust, and faith.

From this hopeful beginning the affiliation agreements between medical schools and VA medical centers have expanded so that now 139 VA hospitals and 103 medical schools are incorporated into the system. Each year 22,000 medical students and 30,000 residents receive a portion of their clinical training at VA hospitals.

There are some who now question whether the statement in the original policy memorandum that "there can be no doubt of the good faith of both parties" is still accurate. There is increasing skepticism about what the VA receives from its medical school affiliations and concerns about the quality and quantity of supervision provided to young physicians being trained in VA medical centers, an issue that strikes at the very heart of quality care. Medical schools are perceived as using their "muscle" to reorganize VA medical centers to conform to their own interests rather than to the interests of the veterans being served.

We must recognize that the VA health care system is in trouble. The changing demographics of the veteran population being served dictate the need for change. A fundamental mismatch exists between the location of veterans and the location of the VA facilities. Former Secretary for Veterans Affairs Edward Derwinski tried to address this problem for two rural hospitals in medically underserved areas when he supported the opening of those facilities to nonveterans in the local population. Proponents of the plan saw it as a way to integrate the VA system with its surrounding community more closely by matching the "excess capacity" of the VA system with the communities' scarce supply of health care resources. The proposal was vigorously opposed by veterans service organizations and their Capitol Hill supporters and ended up costing Mr Derwinski his job.

Another worrisome issue that has conspired to drive a wedge between VA medical centers and their academic partners has been a progressive lack of resources in the VA centers. Because of continued budgetary constraints, there are now major shortages in medical staff, nursing, support staff, and equipment. This dearth of resources has caused disenchantment on the part of faculty, residents, and students assigned to work at these centers. Moreover, the erosion of the research budget by inflation has made VA service progressively less attractive to academic physicians. While medical school deans may threaten to

break off affiliations with their VA hospitals, for many that is not a viable option.

Reason tells us that the future of the VA health care system must be tenuous. If serious efforts are made to develop a national health care system with universal access, the role of the VA in such a system must be explicitly addressed. Senator Jay Rockefeller (Democrat, West Virginia) has positioned himself in a dual role as chair of both the Veterans Affairs Committee and the Health Subcommittee of the Finance Committee to ensure that such an examination takes place.

Conclusion

There will always be a link between academic medical centers and the federal government, but the nature of the relationship must change as political leadership, budget priorities, and programmatic initiatives change. President Clinton's commitment to health care reform and cost containment, to economic revitalization, and to deficit reduction dictates that the programs that have inextricably bound academic medical centers to the federal government since World War II will be examined. Whether those commitments will be renewed, restructured, or repudiated is uncertain.

The evolving social contract that our institutions have with our citizens seems to be changing. What is important now is not only the value of our institutions, but the value of the service they provide to society. Accountability, return on investment, pragmatism, and problem solving are the watchwords of today's social contract. The key for academic medical centers is to be flexible, to recognize the need for change, and to accommodate to the changes demanded by the society in which we live. If we accept the need to change, the firm link between government and academic medical centers that has benefited both parties will surely be strengthened; if we adhere doggedly to the status quo, we will see the link come asunder. In his Inaugural Address President Clinton said it best:

> *Profound and powerful forces are shaking and remaking our world, and the urgent question of our time is whether we can make change our friend and not our enemy.*

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